Date: ____________________

HOUSE OF OPTICAL

Patient Information

Patient Name (legal): ____________________

Preferred First Name: ____________________

Date of Birth: ____________________

Gender (circle): Male Female

Ethnicity: ____________________

Street Address: ____________________

City: __________ State: ______ Zip: ______

Primary Phone Number: ____________________

Secondary Phone Number: ____________________

Email Address: ____________________

Employer: ____________________

Occupation: ____________________

Primary Care Physician: ____________________

Are you interested in any of the following?

Contact lenses?	Y N
Computer glasses?	Y N
Safety glasses?	Y N

Do you experience any of the following?

Blurred vision	Y N
Double vision	Y N
Loss of vision	Y N
Floaters	Y N
Flashes of light	Y N
Dry eye/Eye irritation	Y N
Itchy/Watery eyes	Y N
Mucous/Discharge	Y N
Foreign body sensation	Y N
Sensitivity to light	Y N
Headaches	Y N
Eye pain	Y N

List current/previous eye injury, disease, or surgery: ____________________

Medical History

Diabetes	Y N	Migraines	Y N
Blood Pressure	Y N	Bladder/Urinary Tract	Y N
Cholesterol	Y N	Heart Disease	Y N
Thyroid Disease	Y N	Stroke	Y N
Arthritis	Y N	Gastrointestinal	Y N
Allergy/Sinusitis	Y N	Acid Reflux	Y N
Cancer	Y N	Respiratory/Asthma	Y N
Skin Disorder	Y N	Ear/Nose/Throat	Y N
Depression/Anxiety	Y N	Blood Disease	Y N
Neurological	Y N	Muscle Disease	Y N

Other: ____________________

List Current Medications: ____________________

List any medications you are allergic to: ____________________

List any non-medical allergies: ____________________

Do you smoke cigarettes?	Y N
Do you consume alcohol?	Y N
Are you pregnant/nursing?	Y N

Family Medical History

Diabetes	Y N
Cancer	Y N
Macular Degeneration	Y N
Cataract	Y N
Glaucoma	Y N

By signing below, I certify that the above information is accurate to the best of my knowledge:

Patient Signature: ____________________

Date: ____________________

EG Rx:

CL Rx:

Primary Vision Insurance

Name of Insured Member: Relationship to Patient:

Member Date of Birth: Insured's Employer:

Employment Status (circle one): Full time Part time Retired Unemployed

Insurance Company/Carrier: Group/Policy #:

Social Security Number or Member ID #:

Marital Status (circle one): Single Married Divorced Widowed

Race (circle one): American Indian Asian Black/African American Hispanic White Other

Secondary or Medical Insurance

Name of Insured Member: Relationship to Patient:

Member Date of Birth: Insured's Employer:

Employment Status (circle one): Full time Part time Retired Unemployed

Insurance Company/Carrier: Group/Policy #:

Social Security Number or Member ID #:

Marital Status (circle one): Single Married Divorced Widowed

Race (circle one): American Indian Asian Black/African American Hispanic White Other

Eye Health Screening Tests

A new sophisticated, computerized instrument now allows the doctor to provide a more thorough analysis of your eye and visual pathway. The results of these tests can assist in detection of brain tumors, diabetic retinopathy, glaucoma, stroke, and other disorders. These tests are strongly recommended by medical professionals, especially patients with the following conditions: headaches, diabetes, flashes of light, strong glasses prescriptions, and family history of eye disease.

Retinal Photo Screener Y N
(advanced digital retinal photos)
Visual Field Test: Y N

Both tests: $30 Retinal Screen: $20 Visual Field: $15

Consent & Authorization

I authorize House of Optical to release any medical or other information necessary to process this insurance claim for vision/medical services.

I authorize my insurance company to pay House of Optical for the optical/medical services rendered. I also understand if my deductible has not been met that my claim may be rejected and I will be responsible for any unpaid balances. If your insurance denies payment for services rendered for any reason, we will bill you directly and payment is expected within 30 days. There is a $25 charge for all returned checks.

Patient Signature:

Date:

Privacy Practices & Notices

By signing below, I acknowledge and understand the office's Notice of Privacy Practices. If applicable, I acknowledge that I have received a copy of my contact lens prescription upon finalization of the prescription.

Patient Signature:

Date: